Valley Pain Clinic
Informed Consent for Opioid Therapy

1. It has been explained to me that the use of Opioid drugs (for example, hydrocodone, oxycodone, morphine, hydromorphone, fentanyl, tramadol, Nucynta) leads to a higher risk of accident, injury, falls, car accidents, cognitive impairment, impaired motor skills, breathing problems (including not breathing), accidental overdose and death.
2. I have been informed by my Provider that the initiation of an Opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me, from associated side effects of, and compliance with instructions on the usage of the medication. I have also been informed by my physician that continuation, and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions.
3. I have also been informed that the lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

- I understand that our goal is improved function and not total relief of pain.
- I understand that the higher doses of these drugs lead to even greater risks.
- It was discussed with me that there are not good studies that show that these drugs help those with chronic pain.
- I understand that these medications may sometimes lead to dependence and misuse.
- It was discussed with me that up to 35% of people using these medications may develop addiction.
- I understand that if I have a history of addiction of any kind (including alcohol) I should not take these opioid medications.
- I understand that using Alcohol with opioids is risky and I understand that my provider may take me off opioids if he/she feels that my use of alcohol places me at risk.
- I understand that the use of certain anxiety medications, known as Benzodiazepines ("benzo"), along with opioids is dangerous and that my provider and I should avoid the use of these medications while I am receiving prescriptions for opioid medication. Example of benzodiazepines includes Alprazolam, Clonazepam, Diazepam and Lorazepam.
- I understand that the side effects of these medications may include sedation, constipation, reduced sex drive, personality changes, and falls.
- I understand that opioid medication should not be used routinely for headaches, fibromyalgia, chronic back pain, and/or Chronic Regional Pain Syndrome.
- I understand that my provider will be checking all my controlled drug prescriptions through the Prescription Monitoring Program.
- I understand that if I am on a High dose of opioids (greater than 90 Morphine equivalents daily) my provider and I will work to reduce my dosage to a less risky level.
- I understand that if I am on a High dose of opioid pain medication I will need a prescription for naloxone for treatment of overdose.
- I understand that the use of opioid medications poses special risk to women who are pregnant or may become pregnant. I know that if I plan to become pregnant or believe that I have become pregnant while taking opioid medication, I will immediately call my

Obstetrician and this office to inform them. I understand that while taking this medication, the baby may become physically dependent upon opioids. I also understand birth defects can occur while taking an opioid medication. I understand that the long-term consequence on a child's development who was exposed to opioids is not understood.

- It has been explained to me that there are other treatments that do not involve the use of opioid medications. Having been informed of these risks and potential benefits, I have consented to taking the opioid medication.
- I have read this form or have had it read to me. I understand All of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction by signing this form voluntarily. I give my consent for the treatment of my pain with opioid pain medication
- I understand and agree that failure to adhere to these policies will be considered Noncompliant and may result in Cessation of opioid prescribing by my physician and possible Release from the clinic.

Patient Name: Signature:

Date:

Provider Name: Signature

Date: